CareAmerica Life Insurance Company

P.O. Box 7725, San Francisco, CA 94120
1-888-646-0789

BENEFICIARY CHANGE REQUEST FOR CAREAMERICA LIFE INSURANCE COMPANY (CAREAMERICA LIFE)

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

GROUP NAME	
POLICY NUMBER	
INSURED'S NAME	SOCIAL SECURITY NUMBER

CareAmerica Life will pay the proceeds to the primary beneficiary. If more than one person is named as primary beneficiary, the proceeds will be distributed equally to those who survive the insured, unless otherwise specified in the % column.

SECTION 1 – PRIMARY LIFE INSURANCE BENEFICIARIES

LAST NAME	FIRST NAME	M.I.	%	RELATIONSHIP TO EMPL./MEM.	BIRTH DATE
MAILING ADDRESS (NUMBER, STREET, APARTMENT)	CITY			STATE	ZIP
LAST NAME	FIRST NAME	M.I.	%	RELATIONSHIP TO EMPL./MEM.	BIRTH DATE
MAILING ADDRESS (NUMBER, STREET, APARTMENT)	CITY			STATE	ZIP
LAST NAME	FIRST NAME	M.I.	%	RELATIONSHIP TO EMPL./MEM.	BIRTH DATE
MAILING ADDRESS (NUMBER, STREET, APARTMENT)	CITY			STATE	ZIP
LAST NAME	FIRST NAME	M.I.	%	RELATIONSHIP TO EMPL./MEM.	BIRTH DATE
MAILING ADDRESS (NUMBER, STREET, APARTMENT)	CITY			STATE	ZIP

Proceeds will be paid to a contingent beneficiary only if no primary beneficiary survives the Insured.

SECTION 2 – CONTINGENT LIFE INSURANCE BENEFICIARIES

LAST NAME	FIRST NAME	M.I.	%	RELATIONSHIP TO EMPL./MEM.	BIRTH DATE
MAILING ADDRESS (NUMBER, STREET, APARTMENT)	CITY			STATE	ZIP
LAST NAME	FIRST NAME	M.I.	%	RELATIONSHIP TO EMPL./MEM.	BIRTH DATE
MAILING ADDRESS (NUMBER, STREET, APARTMENT)	CITY			STATE	ZIP

DATE ____________________

INSURED'S SIGNATURE ____________________

WITNESS ____________________

INSTRUCTIONS FOR COMPLETING THE BENEFICIARY CHANGE REQUEST

- DO NOT FORGET to SIGN and DATE this form and make two copies.

- If the named beneficiary is a minor at the time of payment, a court appointed legal guardian of the minor child's estate may be required for payment of proceeds.

- If more than one primary or contingent beneficiary is named, and they are not to share equally, be sure to show percentages, or fraction, not dollar amounts for each.*

- For individual policy holders:
  Send copy of form to CareAmerica Life Insurance Company, P.O. Box 7725, San Francisco, CA 94120.

- For insured persons under a group policy:
  Return this form to your Employer or Association's Administrative office for retention and safekeeping. Keep a copy for your records.

  * If three or more beneficiaries are to share equally, state "In equal shares, or in equal share to the survivors, or all to the survivor."